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U.S. Food and Drug Administration
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Rockville, Maryland 20852

Docket No. 00N-1266: Comments Of Teva Pharmaceuticals USA On The Content Of FDA's Report To Congress On Pediatric Exclusivity Issues

Teva Pharmaceuticals U.S.A. ("Teva") is pleased to provide these comments on the pediatric exclusivity provisions of the Food and Drug Modernization Act of 1997 ("FDAMA"), 21 U.S.C. §355a, in order to assist FDA in preparing its report to Congress on the pediatric exclusivity program, as required under FDAMA. Teva strongly supports FDA's and Congress' goal of improving the quality and quantity of information available regarding the use of drugs in pediatric patients, and Teva initially viewed the pediatric exclusivity provisions of FDAMA as a promising means of achieving that goal. Sadly, however, experience under these provisions has shown that not only will they not live up to their initial promise in terms of producing health benefits for children, but that they also cause substantial harm to other vulnerable segments of the population, such as elderly and lower-income patients forced to pay higher drug prices for a longer time. Thus, Teva believes that a major change of approach should be undertaken after the current

provisions sunset in 2002, and that the pediatric exclusivity provisions should not be re-authorized in their current form.

These comments address the specific issues that must be included in FDA's report to Congress, with a focus on the problems that have arisen under the current pediatric exclusivity scheme, and specific suggestions for legislative change. Under FDAMA, FDA's pediatric exclusivity report to Congress must address "all relevant issues," including:

1. The effectiveness of the pediatric exclusivity program in improving information about important pediatric uses for approved drugs;

2. The adequacy of the pediatric exclusivity incentive;

3. The economic impact of the pediatric exclusivity program on taxpayers and consumers and the impact of the lack of lower cost generic drugs on patients, including on lower income patients; and

4. Any suggestions for modifications to the pediatric exclusivity provisions.

See 21 U.S.C. § 355a(k). Teva's comments on these issues are as follows.

1. The Effectiveness Of The Pediatric Exclusivity Program

The clear Congressional purpose behind the pediatric exclusivity provisions of FDAMA was to encourage drug sponsors to conduct clinical studies that provide meaningful information about the use of a drug in the pediatric population. Unfortunately, branded drug companies and their lobbying arm, the Pharmaceutical Research and Manufacturers of America (PhRMA), have sought to distort this important public health goal by arguing for a scheme in which exclusivity is granted for virtually any study in pediatric subjects, no matter how trivial the study design, and regardless of the medical significance or utility of the data obtained.

PhRMA's desire to pervert the goals of the pediatric exclusivity is well illustrated in comments filed with FDA on October 5, 1999, in which PhRMA complains that the agency has occasionally requested "pediatric efficacy trials" instead of simply requesting superficial information, "from existing data or new trials," on age-specific formulations, dosing, and safety issues. See *Implementing The FDAMA Pediatric Study Incentive Provisions And FDA's Mandatory Pediatric Study Rule*, PhRMA Comments to FDA, October 5, 1999 at 2 (emphasis added). Ironically, PhRMA accuses FDA of "losing sight" of the primary purpose of the pediatric exclusivity incentive, while at the same time arguing that the incentive can be earned based on data that already exists in a drug sponsor's files. The inherent purpose of an incentive is to encourage behavior that would not take place but for the incentive. Offering the reward of six months' additional exclusivity in return for data that were gathered before the pediatric exclusivity provision was even enacted is a complete perversion of the statutory intent.

The intended result of PhRMA's campaign is to convert the enormously valuable six-month exclusivity incentive into little more than an automatic wealth transfer to its member companies from the American public, most significantly from senior citizens and the uninsured. So long as branded companies believe such a goal is possible, they resist and delay conducting serious pediatric studies for all but a few select drugs. Then, as it has already signaled in recent comments, PhRMA will make a last minute push to extend the statutory sunset deadline so that sponsors can finally begin the types of studies that should have been begun, and completed, years earlier.[1] Thus, the branded companies have cynically treated the pediatric exclusivity provision as

[1] For example, PhRMA's October 5, 1999 comments erroneously argue that any NDA filed prior to January 1, 2002 is eligible for pediatric exclusivity after that date. PhRMA Comments at 20. However, FDAMA clearly authorizes FDA to set timeframes for completing pediatric studies as a condition of exclusivity, and such timeframes can obviously end on the sunset date of the statute itself. Indeed, it would be bad policy to reward PhRMA's cynical strategic behavior by allowing exclusivity periods to extend beyond January 1, 2002 in any event.

a means to get something for nothing,[2] seriously undermining FDAMA's ability to serve as an effective means of generating important pediatric medical information.

Teva commends FDA for resisting PhRMA's intense pressure to trivialize the pediatric exclusivity provisions. Nevertheless, for the reasons discussed herein, Teva believes that even the most prudent implementation of the pediatric exclusivity provision as currently enacted cannot make it a truly effective tool for achieving the important public health goals intended by Congress. Accordingly, FDA should recommend to Congress that the pediatric exclusivity provisions not be re-codified in their present form after the January 1, 2002 sunset date for those provisions.

2. The Adequacy Of The Exclusivity Incentive

Teva believes that the relevant issue is not whether the pediatric exclusivity incentive is "adequate" to foster meaningful pediatric research, but rather whether the incentive is too generous. Judging by the energy with which PhRMA has attacked FDA in connection with every perceived delay or barrier to obtaining exclusivity, the exclusivity extension is clearly a very strong incentive. Whether that incentive is "adequate," however, can be judged only in relation to what investment is necessary to obtain the exclusivity, the public health benefits accruing from such investment, and the attendant costs to society. Congress left it largely to FDA to determine the substantive eligibility requirements for studies to qualify a drug for pediatric exclusivity and the agency has, for the most part, applied an appropriately rigorous standard, despite protests from drug sponsors that exclusivity should be easier to obtain. However, if the study eligibility

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[2] This does not, however, mean that the incentive itself – six months additional exclusivity – is not "adequate" to spur meaningful pediatric research, as discussed in section 2 of these comments.

requirements are as minimal as PhRMA has repeatedly argued they are, the six-month exclusivity period would be far too strong an incentive – indeed, it would be nearly a pure windfall.

In many cases, six months' additional exclusivity is worth hundreds of millions of dollars to the brand name drug company, many orders of magnitude more than the cost of even full-scale NDA efficacy studies (much less pediatric-specific studies). Unfortunately, this enormous monetary benefit is taken directly from those individuals – specifically the ill, the elderly, and the uninsured – who can least afford to subsidize extra monopoly profits for brand name drug companies who receive the exclusivity. In this light, it defies logic and common sense to think Congress intended to allow exclusivity in exchange for narrow, simple, and relatively cheap studies of the kind PhRMA proposes.

PhRMA bears a heavy burden, which it has utterly failed to meet, to explain why such limited studies, purportedly in support of important health benefits to children, require such enormous financial incentives in the first place. If PhRMA members are as committed to children's health as they purport to be, they should be more than willing to invest the relatively small sums of money required to conduct these kinds of limited, small-scale studies without having to obtain six months of exclusivity in return. Indeed, the financial windfall of six months exclusivity on just a single top-selling drug could likely finance trials of the type PhRMA endorses for many currently approved drugs.

Congress clearly intended the exclusivity reward to come into play only in situations where a significant research investment produced clinically meaningful information – not situations where companies calculate the bare minimum they can get away with in terms of clinical "research" in order to qualify for the windfall of six months' added exclusivity. In the former situations – envisioned by Congress – the exclusivity incentive is somewhat more defensible from

a public health policy standpoint. It is still open to question, however, whether such an incentive is necessary in the first instance given the other statutory incentives available as a reward for medically important pediatric research, or whether alternative incentives could accomplish the same goals without producing such a damaging impact on other vulnerable sectors of society.

In this light, the support of a group such as the American Academy of Pediatrics for the pediatric exclusivity provision, while well-intentioned, must be put in the proper perspective. In the first place, the AAP is justifiably responding to a situation in which virtually nothing was being done before to augment our knowledge about the use of approved drugs in children. Against this backdrop, a pediatrics group would understandably welcome any initiative with a chance of filling the gaps in that knowledge. More importantly, the AAP by definition is focused on the health needs of children first and foremost. While that is a noble and laudable focus for a private medical group, Congress must balance the interests of *all* affected segments of society. A law that provides only modest benefits to children's health at the cost of disproportionate damage to the pocketbooks – and ultimately, the health – of elderly, uninsured or underinsured, and lower-income citizens is simply not good public policy.

3. The Adverse Economic Impacts Of The Pediatric Exclusivity Scheme

It was always recognized that the pediatric exclusivity provisions would impose a substantial cost upon the American public, and in particular elderly, low income, and underinsured patients, as well as governmental and private insurers. The generic drug industry, which is the key force in keeping drug prices down, is also directly harmed by exclusivity extensions. Although it is difficult to quantify the benefits obtained to date from the pediatric exclusivity provision, it is

clear that in today's environment of concern about higher drug costs, Congress must weigh very carefully the economic impact of delaying generic competition in major drug markets.

More troubling is the magnitude of the costs that would be imposed upon American consumers if the liberal study eligibility standards sought by PhRMA were to be accepted in granting exclusivity. Given real-world experience in implementing the pediatric exclusivity provisions since FDAMA was enacted, it is now clear that PhRMA will take advantage of any opportunity to extend drug exclusivity in exchange for the most limited investment it can get away with.

4. Suggestions For The Future

As discussed above, the pediatric exclusivity program is plagued by serious problems and is being abused by branded drug companies in a cynical effort to obtain huge undeserved windfalls at the expense of the American public.[3] Thus, Teva urges FDA to recommend that Congress dramatically restructure the pediatric exclusivity scheme, or to simply allow the pediatric exclusivity provisions to sunset as scheduled on January 1, 2002. In considering changes to the pediatric exclusivity provision Teva offers the following recommendations:

- Pediatric exclusivity should be granted only where clinical trials result in FDA approval of significant new pediatric labeling for the product at issue.
- Exclusivity should attach only if a pediatric labeling change is approved by FDA prior to patent expiration.

[3] According to our estimates, the additional profits to be gained by brand companies from the pediatric exclusivities awarded to date, exceeds $800,000,000. This is directly at the expense of the consumer, government, and private insurers.

- The exclusivity program should use a disease-state/treatment-based approach such that once safe and effective treatments are available in a particular therapeutic class, no further exclusivity will be granted to a drug in that class unless a clear advantage over existing treatments can be shown. (Such an approach is analogous to that used in the orphan drug context, where a subsequent sponsor must show clinical superiority in order to defeat a previous sponsor's orphan exclusivity for a particular drug and qualify for its own exclusivity.) This would encourage better and faster pediatric studies, and achieve the important objective of providing reliable pediatric treatment without unnecessary duplicative studies of similar members of a drug class.
- Rather than rewarding sponsors who conduct meaningful research with additional exclusivity, such companies should be rewarded with benefits that do not simultaneously harm the most vulnerable segments of American society by delaying lower price competition for the drugs at issue. Targeted tax incentives would be one possible alternative incentive.
- Sponsors seeking pediatric exclusivity should be required to publicly disclose all information in their possession relating to the use of the drug in children (including unreported studies, adverse event reports, correspondence from practitioners, etc.), so that FDA may assess the relevance of that information to the need for, or scope and design of, additional pediatric studies.
- Pediatric study proposals should be made public immediately so that all interested parties may evaluate and comment prior to subjecting children to the risks of the study. This will also serve to prevent the type of "gaming" of the system that PhRMA and its member companies have engaged in under the current pediatric exclusivity scheme.

- Congress should specifically provide that pediatric studies may not be required for products approved under section 505(j), either under FDAMA, or under any independent FDA regulations.
- Pediatric exclusivity should be explicitly limited to the approved drug product for which the required clinical studies were conducted, and not granted to all other drug products containing the same active moiety.
- Pediatric exclusivity should be specifically limited to patents that are listed in the Orange Book as of the date FDA issues its study request, so that pediatric exclusivity does not become an "evergreen" exclusivity by way of sequential application to late-listed patents.
- Eligibility for pediatric exclusivity must be limited to drugs with a substantial therapeutic potential in children, as demonstrated by the sponsor of the proposed pediatric study.

Teva appreciates the agency's willingness to accept these comments in advance of its report to Congress.

Respectfully submitted,

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